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FEMALE CLIENTS IN SUBSTANCE ABUSE TREATMENT:  
AN UPDATED REVIEW

by  
Theresa Ann Lescher

A Thesis Submitted to the Faculty of the Graduate School  
of Loyola University of Chicago in Partial Fulfillment  
of the Requirements for the Degree of  
Master of Arts

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## VITA

The author, Theresa Ann Lescher, is the daughter of Alfred J. Lescher and Theresa (DeFrank) Lescher. She was born August 8, 1962, in Chicago, Illinois.

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## INTRODUCTION

The National Institute of Alcohol Abuse and Alcoholism (NIAAA, 1985), reports that alcohol is the most frequently abused substance by women (Bry, 1983), and more than sixty percent of adult American women and nearly ninety percent of college women drink alcoholic beverages (NIAAA, 1985). The number of women who abuse alcohol is conservatively estimated to be over 2.5 million, most of whom are hidden or not diagnosed. Until recently, however, little research was available on female alcoholics and drug abusers and most treatment programs were developed from the research literature on male substance abusers. As a result, a number of researchers, clinicians, and policy makers (e.g., Marsh & Miller, 1985; Blume, 1986; Taylor & St. Pierre, 1986) have called for research on the female alcohol and drug abuser that could provide the focus for the development of treatment programs geared specifically to the needs and characteristics of the female substance abuser.

The purpose of this thesis is to review and update literature on the female substance abuser published since 1982. 1982 was chosen as a starting date for the literature review because an extensive prior review (Marsh & Miller, 1985) summarized the literature published before 1982. This thesis will, therefore, use the Marsh and Miller (1985) review as a

starting point and will address the following three questions: (1) Have the treatment recommendations provided by Marsh and Miller been implemented? (2) Have new data been forthcoming on research questions noted by these authors? (3) Have data been generated on new issues not covered in the Marsh and Miller (1985) review? The overall goal, therefore, is to provide an up-to-date summary of the knowledge on women substance abusers and treatments developed for them.

## SUMMARY OF SEX DIFFERENCES IN DRUG AND ALCOHOL USE

Marsh and Miller (1985) reported the following differences between men and women in the area of drug and alcohol abuse: (1) women use licit (legal) drugs more often than men do, (2) they are written more prescriptions, (3) it is more common for women to experience cross addictions, (4) they use substances alone more frequently than men, and, (5) women are usually more likely to be introduced to drugs by men. Many studies have been written since Marsh and Miller's (1985) review and they add more information to the earlier findings.

Reports on the proportion of male alcoholics to female alcoholics in active treatment vary. Some programs report that they service two males for every female, while others go as high as ten males for every female (Reed, 1985). Six males for every female is reported in institutional settings while physicians in private practice claim that their patients with alcoholism are equally male and female (Hennecke & Gitlow, 1985).

Although one literature review (Taylor & St. Pierre, 1986) reports that male and female alcoholics share similar personality traits, others suggest that alcohol affects men and women in different ways (Acker, 1986). Men and women react differently to problem alcohol consumption (Taylor & St. Pierre, 1986) and the evidence points to alcohol having more of a deleterious effect on women than on men (Acker,



1986). In their article on alcoholism in women, Hennecke and Gitlow (1985) proposed that women alcoholics are more likely to attempt and complete suicide than men alcoholics, and Blume's (1986) article asserts that women are more likely to have a history of previous psychiatric treatment. Women can usually accurately estimate when their drinking became a problem and this is often attributed to a stressful time in their lives whereas men do not estimate as accurately when their drinking became a problem (Blume, 1986). Some of the stresses that women report include limited job opportunity, lower pay, single parenting, sex discrimination in financial transactions, and the underevaluation of woman's work (Blume, 1986).

Differences in drinking patterns of males and females have also been noted. In another report by Blume (1982) it was noted that boys tend to drink in all male or male/female groups, while girls most often drink in mixed sex groups. Women are less likely to frequent bars or drink as heavily as men in public places (Hennecke & Gitlow, 1985); it is more likely that a woman will drink alone or at home and a greater stigma is placed on women alcoholics than on men (Lester, 1982).

It is more common for alcoholic women to be involved with alcoholic men than visa versa, and alcoholic women are more likely to be the victims of domestic violence (Blume, 1982).

Women alcoholics seem also to be more similar to their nonalcoholic counterparts than are men. Women in detoxification seem to be more similar than men to the general population in the areas of marital status and employment; women alcoholics and nonalcoholics have similar rates of employment and marital status whereas men alcoholics are not similar to their nonalcoholic counterparts on these variables (John, 1987). Using a documentation sheet developed for an epidemiological study, John (1987) reported that women also tend to seek treatment more frequently than do men; "more of them had been patients three or more times before." Pinhas (1987) states that "excessive alcohol use may be a primary recreational activity for younger women, a void filling activity for older women, and a femininity enhancing activity for most women." Widows, single dependent men, and blue collar workers are all overrepresented in treatment centers.

The motivation to enter treatment also appears to be different for men and women. According to Blume's (1986) review, men tend to enter treatment after job and legal problems have appeared, while women enter for health and family problems (Blume, 1986).

Since alcoholism in women often takes on the form of passiveness and depression, recent evidence suggests that it is often misdiagnosed as an affective disorder and drugs are prescribed. (Hennecke & Gitlow, 1985). Alcoholics Anonymous (AA) and others (Blume, 1986; Ogur, 1986) reported

that 40 percent of female members as compared to 27 percent of males, reported addiction to an additional drug. There have recently been a number of explanations offered for these findings. In a study conducted by Halliday, Bush, Cleary, Aronson, and DelBanco (1986), women seeking gynecological care at two private practice settings were asked to fill out questionnaires that included an alcohol screening test. Twenty-one percent of women with premenstrual syndrome were abusing alcohol, while 12 percent of women receiving periodic gynecological care abused alcohol. One way of relieving PMS is through prescribed drug therapy which may cause further problems in alcoholic women. If alcoholic women are prescribed drugs for hormonal symptoms (Ogur, 1986), the use of these addictive drugs can hide or exacerbate the alcoholism (Fortin & Evans, 1983).

Wilsnack, Wilsnack and Klassen (1984/85), therefore, recommend that more attention be given to women's multiple substance abuse. Drug abuse can cause problems during the menstrual cycle such as dysmenorrhea and amenorrhea. These conditions alter birth control and pregnancy detection methods (Bry, 1983). Fetal alcohol syndrome is greater (23-29 per 1,000 births) in alcohol abusers than in the general population (1-3 per 1,000 births) (Rossett et al, 1983).

Ogur (1986) suggests that another reason women are over-represented in prescription drug addiction may be that there is still a negative stereotyping of women, (i.e., women are

seen as weaker and therefore are prescribed drugs to take care of personal problems). Ogur (1986) goes on to note that in much of the pharmaceutical companies' advertising, women are shown as passive and helpless; while men are shown as partners in problem solving. Ogur also suggests that physicians may overprescribe to women because women tend to express emotions openly. This, according to Ogur, may be seen by a physician (particularly a male physician) as being pathological, so he prescribes drugs to keep the woman in control.

Not much concern has been shown on the issue of prescribing products containing codeine. Codeine is the second most prescribed drug (Ogur, 1986). For women, it seems that cocaine is related to sexuality and relationships with men (Washton, 1986). In her article on women and cocaine, Washton (1986), reports that 87 percent of the women surveyed said that men introduced them to cocaine and 67 percent received it as a gift from a man. The reasons she found for the women's use of cocaine were "extra energy, relief from tension, heightened sexuality or suppression of appetite." Some women also reported using cocaine "to go along with their male companion." This pressure to "go along with" may be relevant in the use of illicit drugs but Ogur (1986) reports that peer pressure is not an issue with female prescription (licit) drug abuse. As with female alcoholism, female prescription drug abuse keeps a low profile.

Miller (1984), in a study comparing substance abuse patterns among male and female inmates, found that significantly more females (10.8%) than males (4.5%) used psychotropic drugs for stress related conditions and that the daily use of all types of medications was greater for women (37.2%) than for men (17.6%). This study also reported that slightly more female inmates had used heroin (36.9%) than had male inmates (29.5%).

In summary, recent studies continue to support Marsh and Miller's (1985) conclusions that women more often experience cross-addiction than do men and that they are prescribed drugs more often than men. Additional evidence appearing in the more recent literature suggests that alcohol may have more detrimental effects on women than men (e.g., higher suicide rates among women alcoholics) and that women may be more prone than men to drink in response to stressful life events. The findings on the detrimental effects of alcohol on women gain further support from studies cited in the next section of this paper.

## FACTORS RELATED TO SUBSTANCE ABUSE

### Effects of Alcohol Consumption on Physiological Functioning

According to Marsh & Miller (1985), health problems characteristic of female abusers are gynecological infections and disorders, hepatitis, suicide attempts, and neurological disorders. Women abusers were also reported by Marsh and Miller to have more general health concerns than their male counterparts.

However, problems have precluded gaining accurate information on the effects of alcohol on women's physiological functioning. First, most studies have been conducted with male alcoholics; second, the few studies using samples of alcoholic women have used samples too small to draw inferences about the effects of alcohol on women in general. Nevertheless, two informative recent studies have found that, after controlling for past drinking histories, women seem to be more impaired than men from the effects of alcohol (Acker, 1986, Blume, 1986). Acker (1986) administered tests of cerebral functioning (i.e., Logical Memory, Benton Visual Retention, Trailmaking, Digitspan, and the New Adult Reading Test) and found that women performed significantly worse than did men on immediate recall and psychomotor speed tasks. Blume (1986) also reported that alcoholic women reached the same level of impairment as alcoholic men after drinking 45 percent less

than alcoholic men.

Although, reasons for these findings are not clear, evidence suggests that when body weight is controlled, women reach a higher blood alcohol level than do men after consuming the same amount of alcohol, and that these sex differences are even more apparent during women's premenstrual phase (Blume, 1982). Thus, it may be that sex differences in memory and psychomotor functioning are due primarily to women's increased blood alcohol level and not to differences in drinking rates of men and women. These findings further suggest that diagnostic criteria for alcoholism may need to be different for men and women.

In addition to these apparent sex differences in the effects of alcohol on memory and psychomotor functioning, recent literature has suggested male and female differences in the onset of alcohol related disease rates. Although the actual incidences of alcohol related diseases (e.g., cirrhosis of the liver) appear to be similar for men and women, recent literature, has reported that these diseases seem to develop earlier for women than for men (Acker, 1986; Blume, 1986; Litman, 1986).

Hennecke and Gitlow (1985) suggest in their article that alcoholic women also have a higher rate of mortality than their male counterparts and their life expectancy appears to be decreased by about 15 years as compared to nonalcoholic women.

Female alcoholics, as reported in Lester's (1982) article, start drinking later than male alcoholics but both come to treatment at about 40 years of age, with women going from controlled to uncontrolled drinking more quickly than men.

Recent studies have shown that alcoholic women also have problems in the area of sexual functioning, but that their problems in these areas are not more prevalent than those of nonalcoholic women. Although alcoholic women are usually described as frigid and anorgasmic (Pinhas, 1987), sexual dysfunction is much higher among alcoholic men than alcoholic women. Jensen (1984) conducted a study to look at the sexual functioning of young married alcoholics. Jensen's results suggest that there is no significant difference between alcoholic women and a control group of non-alcoholic women in sexual dysfunction.

Many people with the expectation that alcohol will diminish fears and inhibitions, believe that they have more arousal, sexual interaction, and try more sexual activities when they are drinking (Pinhas, 1987). However, Jensen (1984), using married alcoholic men and women in treatment, administered a sexological questionnaire and follow-up interviews, and found that although more arousal was reported by women after ingesting alcohol, physiologically, the more alcohol consumed, the less arousal.

It has been further noted that many alcoholic women have



alcoholic partners, and the combination of the two of them together may make sexual problems worse. Pinhas (1987) recommends that if a patient reveals sexual problems, a drinking or drug (illicit and prescribed) history should be taken before a diagnosis is made.

Marsh and Miller (1985) mentioned gynecological, neurological, and general health problems as characteristic of female substance abusers. Recent information agrees with earlier findings and adds that women may be more susceptible to the deleterious effects of alcohol during their premenstrual phase. With this new finding, physicians may begin to understand the progression of alcoholism in women.

#### Effects of Substances on Psychological Functionings

Marsh & Miller (1985) suggested that women abusers experience lower self-esteem and a poorer self concept than their male counterparts, although male and female heroin addicts have similar levels of psychopathology.

The current literature supports these findings and includes several other factors that differentiate men and women alcoholics in the area of psychological functioning. In a longitudinal study of college students, Fillmore, Bacon, and Hyman (1979) found that for women, the "best predictor of problem drinking" was a high score on a feeling adjustment scale (designed by the authors). This scale included items such as drinking to relieve shyness, to get high, and to get along better on dates. For men, college drinking habits were

the best predictors.

Blume's (1986) paper on "Women and Alcohol" asserted that low self-esteem and inability to cope in teenage girls predicted problem drinking. The inability to cope, as noted in an article by Lester (1982), may cause much stress and deprivation in the life of a female alcoholic. The difference between men and women alcoholics under stress is that the women tend to report higher symptom intensities even though their perceptions of stress is reported to be the same (Ogur, 1986). Women, in contrast to men, can often date the beginning of their drinking to a particular stressful event. Events such as bereavement, divorce and an "empty nest" seem to put middle age women at a higher risk of excessive drinking, as reported in an article by Allan and Cooke (1986).

According to Lester (1982), alcoholism in women may also be related to insecurity in the feminine role, dependency, low self-esteem, fear of inadequacy and sensitization to loss. In a study conducted by Hoar (1983) to determine if women alcoholics are different from other women, subjects answered questionnaires that measured relative degrees of field dependence, level of ego development and perceptions of self. Alcoholic women tended to be more psychologically dependent than nonalcoholic women and influenced more by significant others. It was also noted that the alcoholic group of women had a large difference between their ideas of "self" and "own

ideal".

Lester (1982) also suggested that women are more likely than men to drink to gain strength and feel lively, to blot out a sense of meaninglessness, and to relieve loneliness and feelings of inferiority.

In Marian Sandmaier's (1976) "Guide for Helping Alcoholic Women", she writes that many women feel trapped in their homemaker role and resent not being able to go out and live their own lives. This frustration, she suggests, leads women to seek the escape of alcohol.

Braiker (1982), in a NIAAA Alcohol and Health Monograph, asserted that women are more likely to show signs of affective disorders and chemical dependency. More women seek psychiatric care than men and they tend to have very specific gender identity concerns (Wilsnack, 1982). And after administering the MMPI to alcoholic men and women, Kline and Snyder (1985) suggested that the MMPI can predict alcohol consumption and substance abuse by the level of psychopathology.

These findings agree with Marsh & Miller (1985) that women alcoholics have a more serious problem than do men alcoholics in the area of self-esteem and self-concept. Other findings in the recent literature include: women usually date their problem drinking as coinciding with a particularly stressful event; women drink to relieve loneliness and a sense of worthlessness, and that more women than men abusers show signs of affective disorder.

## Effects of Substances on Family Functionings

Marsh & Miller (1985) reported that women abusers are more likely than men abusers to come from substance abusing and disorganized families, have substance abusing spouses, and addicted women were more likely to have children than were non-addicted women.

In agreement with Marsh and Miller's (1985) findings, Midanik (1983) noted that family disruption and deprivation during childhood seems to be more prevalent and severe for women alcoholics as compared to male alcoholics, and that women are more likely to have alcoholism in their families. About half of the women with alcohol problems and one-fourth of the men with alcohol problems report at least one problem drinker in their family. Upon Administering the Michigan Alcoholism Screening Test (MAST) to the families of alcoholic men and women, Leckman, et al, (1984), reported that there was a greater tendency for the families of the women to score positive on the test indicating alcoholism (37.7%) than the families of men (24.4%).

Fortin and Evans (1983) studied the loss of control (inability to control the extent of drinking so that drinking usually led to intoxication) of drinking and related it to family drinking histories. The findings indicated a negative relationship between family drinking history and female loss of control (i.e., the more alcohol used by parents the less time it took for women to lose control of

their drinking). It was also found that single women and women with few or no children developed a loss of control of their drinking about twice as fast as women who were married, divorced, or had children.

Blume's (1986) article noted that many alcoholic women come from nontraditional families (i.e., dominant mother, weak father) which may leave the woman insecure in her female role. Finally, among women, married women had a tendency to show fewer cases of alcoholism and those women cohabitating had significantly more cases of alcoholism.

In articles written by Binion (1982) and Kovach (1983), it is mentioned that chemically dependent women are usually introduced to drugs by men (i.e., doctors, spouses, boy-friends) and that incest and family violence is very high among chemically dependent women.

Recent literature has noted trends in the relationship status of alcoholic women. Because most husbands leave their alcoholic wives (Hennecke & Gitlow, 1985), alcoholic women are likely to be divorced when they enter treatment. These women, if they do have a partner, have a partner who is usually substance dependent himself and will not support her treatment unless he is ready for it himself (Blume, 1982, Knupfer, 1982).

Marsh and Miller (1985) noted the disrupted family life that female abusers tend to experience. Recent findings support this notion and continue to find that many women

abusers' spouses leave them, many have alcoholism in their families, and they develop a loss of control of their drinking more quickly if they are single and have few children.

### Effects of Substances on Employment Status

According to Marsh & Miller (1985), women abusers and nonabusers are employed less than their male counterparts. Also, Marsh and Miller (1985) reported a positive relationship between rates of alcoholism, age, and economic status in women, whereas in men the same relationship was not found.

Solomon (1983) maintains that women's attitudes have changed and they are increasingly found in the work place which can lead to an increased drinking habit among them. Forty percent of the labor force are women, but when comparing them with men, proportionately fewer women are referred to occupational alcohol programs.

Kleeman and Googins (1983) stated that increased exposure to alcohol and pressure to conform to work related situations and unclear norms can lead to increased drinking problems in women.

Women in the workplace may also have a problem because norms for their drinking behavior are not specified. In the book "Prevention of Alcohol Abuse", Noel and McCrady (1984) stated that drunkenness and heavy drinking is not as socially accepted for women as it is for men. The combination of women in a new area (the workplace) with unclear norms, may lead to a confusion that can cause some women to drink heavily. A

dissertation by Kleeman (1982) points to the conclusion that supervisors tend to treat men and women alcoholics differently. One possible reason for this is sexism which pictures women as the weaker sex and therefore they may be pampered more throughout treatment.

On the other hand, Fortin and Evans (1983), while studying loss of control in women alcoholics, found that for some women, full time employment was associated with later onset of alcoholism. Single and unemployed women have also been reported to be at greater risk for developing alcoholism and if it does develop, it happens more quickly. While in treatment, employment was positively related to length of abstinence.

Since women are more common in the workplace now, their economic status is changing for the better. With increased stress from working and an increased income, cocaine is becoming more accessible to women, and more women are also becoming more involved with it. Cocaine seems to be useful in reducing stress and in weight control (Allan & Cooke, 1986).

Marsh and Miller (1985) have listed some sex differences between men and women alcoholics, and the current literature points to the idea that women seem to be especially susceptible to the deleterious effects of alcohol due to hormonal fluctuations and general body make-up (less water content for women than men).

Many physiological and psychological problems affect women substance abusers. These, together with everyday stresses of functioning (i.e., family, job) may lead women to drastic measures. Suicide, a very drastic measure, is more commonly reported among women abusers than among men abusers.

The family functioning of substance abusing women may also be a problem for them. Many substance abusing women come from families with substance abuse problems. Further, alcoholic women are most often divorced, single, or cohabiting with an alcoholic partner.

The findings are, however, much more mixed on the relationship of work to alcoholism in women. On the one hand, several writers have suggested that the increased stress associated with work combined with unclear norms about appropriate drinking may "cause" an increase in substance abuse rates among working women. Recent data, however, suggest just the opposite (i.e., that employment status was associated with later alcoholism onset among women and that unemployment rather than employment seemed to be a major risk factor for women alcoholics). Thus, it is clear that more research needs to be done to "tease out" the positive and negative effects of work on female alcohol consumption and alcoholism rates.



## SERVICE UTILIZATION

According to Marsh and Miller (1985), studies on women substance abusers and their use of treatment centers is a neglected aspect of research. Among the few studies conducted, the conclusion seemed to be that among low socio-economic status women the help-seeking strategies were similar for addicted and nonaddicted women; most women sought professional help only after they had exhausted their informal social supports.

When searching for current research on service utilization, literature was again seriously lacking. Instead, studies have been conducted and literature written to assess barriers of women abusers to entering treatment service. Amaro and Beckman (1984) studied the service utilization of alcohol treatment agencies and found that although the public is becoming more aware of the problem of women and substance abuse, women still face many barriers to treatment, including: (1) lack of employment and lack of financial independence, (2) less favorable attitudes than men toward health professionals, and (3) a greater likelihood of drinking alone and of remaining a hidden alcoholic. Beckman and Kocel (1982) also asserted that admission criteria, lack of gender sensitive casefinding systems, male oriented treatment models, sexism and harassment within treatment programs, the different

help seeking patterns of women compared to men, social stigmas and/or protection of chemically dependent women, family responsibilities, and economic barriers all lead to a lack of women alcoholics seeking treatment. Leland's (1984) article reports that lack of child care, fear of losing children, and lack of culturally appropriate programs have been a barrier to entering treatment among female ethnic minorities.

Another problem found by Rice and Shaw (1984) in a study conducted to measure staff attitudes towards clients of each sex was that if a woman was found not suitable for the facility she sought, she was more likely to have difficulty obtaining access to any treatment facility.

When women decide to enter treatment, they report many more negative consequences than do men, including disruptions in family relations, feelings of loneliness and discomfort, lack of money, avoidance by friends and co-workers, loss of friends, and anger of spouse (Beckman, 1984). Authors and researchers have also noted that families and friends tended to oppose treatment more for women than for men alcoholics (Beckman & Kocel, 1982, Beckman, 1984, Beckman & Amaro, 1986), with men alcoholics findings more social support for their decisions to enter treatment. Beckman and Amaro (1986) also found that when treatment was suggested for the woman, the suggestion usually came from her parents, whereas for men, the spouse most often recommended treatment.

Although employee assistance programs (EAPs) are becom-

ing a popular way of getting people into treatment, they have not appeared to be very successful in getting women alcoholics to seek help because women report a lack of trust in their companies (Reichman, 1983). Anderson (1983) stated that one of the most effective ways of attracting women clients is to develop high quality women-oriented services and to advertise them in places women frequent (e.g., child care centers, supermarkets, beauty parlors, and workplaces that employ women). Word-of-mouth advertisement can also be very effective.

According to Beckman and Kocel (1982), programs with specialized women's services seem more effective in attracting women into treatment. In their review of the literature on alcohol research conducted with women, they assert that women are more prevalent in agencies that hire more professionals, provide treatment for children, and provide aftercare services.

Beckman and Kocel's (1982) article also found that more women participated in programs that were: (1) private rather than public, (2) treated drug as well as alcohol addiction, (3) had aftercare services, (4) provided treatment for children, and (5) obtained referrals from informal networks.

Other services that alcoholic women report as appropriate for them are counseling, support groups, therapy for battered women and incest victims, treatment for prescription drug addiction, job counseling, and medical and nutritional

counseling for pregnant women (Beckman & Amaro, 1986).

A summary of treatment entry barriers for women as established by Reed (1985) is presented in Table 1 (page 24). Children, economic resources, services provided by the center, and support systems are all listed as potential barriers for women entering treatment.

Articles written by Beckman (1984) and Beckman and Amaro (1986) further recommend that since there is still a greater stigmatization of women alcoholics, community gatekeepers, family and friends need to be educated about the women's illness in order to facilitate rather than hinder the early identification and treatment. Some potentially facilitating effects of such education efforts were suggested to be a decrease in stigmatization, a more positive attitude by significant others, and a decreased feeling of threat in the alcoholic woman herself.

Thus, it appears that the current literature, although sparse, continues to support Marsh and Miller's (1985) findings that alcoholic women under utilize services (i.e., many fewer women use treatment services than would be suggested by prevalence rates of female alcoholics in society) (Gomberg, 1981; Litman, 1986). However, recent research has seemed to increase our knowledge about the types of barriers that women encounter in their efforts to use and benefit from treatment services. These data could be used in future research to design and test treatment programs for alcoholic women. Some

Table 1

## Problems in Treatment Entry

Barriers to Treatment Entry	Barriers to Engagement in Treatment
1. Lack of economic resources	1. Low self-esteem
2. Child-related responsibilities	2. Too many other responsibilities
3. Lack of women-oriented services	3. Lack of comprehensive assessment
4. Referral network less sensitive <ul style="list-style-type: none"> <li>a. Stigma/stereotype</li> <li>b. Lack of knowledge</li> <li>c. No case finding systems in places women seek help</li> </ul>	4. Sexism <ul style="list-style-type: none"> <li>a. Stereotypes, insensitivity</li> <li>b. Demeaning roles</li> <li>c. Sexual harassment</li> </ul>
5. Lack of interpersonal support network	5. Inadequate sensitivity to gender related interpersonal and group dynamics
6. Women attend to others needs more than their own	6. Gender of intake workers and counselors
	7. Styles of early treatment stages
	8. Groups and organizational gender compositions and dynamics

possible components of treatment programs that are likely to be used by women are child care, vocational and educational training, gender sensitive counseling, and programs to enhance self-esteem and self-concept among women abusers.

## SERVICE EFFECTIVENESS FOR DRUG DEPENDENT WOMEN

"Because women's lives differ significantly from those of men in our culture, both early recovery and aftercare programs for women need to base the design and the delivery of their services on the realities of women's lives and the problems specific to women with alcohol problems" (Underhill, 1986 p. 46). This statement by Underhill (1986) in her article on aftercare programs for women seems logical enough, but, historically, as shown in a study by Vannicelli and Nash (1984) that measured sex bias on women's studies on alcoholism, women alcoholics (and drug abusers) have been grossly under-represented, in research studies far out of proportion to the difference in male-female prevalence rates. Marsh and Miller's (1985) review agrees with this statement, as they note that research examining the effects of programs on women substance abusers is extremely limited. They also noted that in the few studies done, many problems arise when trying to assess service effectiveness. Research designs appeared to have problems in selection, attrition, and comparison groups, while the measurement techniques did not appear to be appropriate. Of the research conducted with women, Marsh and Miller (1985) also found that much of the data compiled was combined with male data.

In a more recent study conducted by Vannicelli & Nash

(1984) to determine the representation of alcoholic women in research studies, it was found that only 7.8 percent of subjects were women (sample 764,000). In studies conducted by female authors, women represented 13.4 percent of subjects while male authors had women representing 4.3 percent of their subjects. In follow-up studies, women subjects were 1 1/2 times more likely to be followed up if the author was a woman. Women investigators were also more likely than male investigators to examine sex differences in treatment outcome and analyze woman's data separately.

Briefly, it seems that service effectiveness continues to be a limited area of research.



## METHODOLOGICAL ISSUES IN ASSESSING SERVICE EFFECTIVENESS

In the area of research design, Marsh and Miller (1985) noted that a lack of data is a fundamental problem in assessing women's programs. Another problem noted is that of outcome studies using only "graduates" of their programs as samples; this factor skews outcome studies.

In their articles on substance abuse, Alexander & Hadaway (1982) and Conley & Prioleau (1983) asserted that there is no such thing as an addictive personality. Performance within the alcoholic group is notoriously variable (Parsons, 1977), ranging from the severely impaired to the entirely normal. Acker (1986), at the end of her study on gender differences in neuropsychological defects in alcoholics, noted that by simply belonging to the group called "alcoholic", attributes and implications exist that forever separate this group from others. These implications are lost when so-called matched nonalcoholic groups are used, as the two groups may be inherently different so that no valid comparisons could be made between them. Amaro & Beckman (1984), after looking at studies of women in alcohol treatment, state that the small number of studies comparing individuals in alcohol treatment to those not in treatment failed to investigate sex differences and that most data on women alcoholics are based on in-treatment samples and, there-

fore, have limited generalizations to individuals not in treatment. Limitations of studying clients in treatment are that these clients probably experienced lower opposition to treatment and the costs of treatment than those who have not entered treatment (Beckman & Amaro, 1986). This again limits generalization.

Many other problems have been identified with methods and the instruments used to measure research outcomes. Dunham (1983) suggested that we stop trying to identify problem drinkers by measuring their drinking patterns over a 30 day or 3 month period, but instead, try to establish a life time drinking pattern instrument. Hoar (1983) and McCrady and Sher (1983) noted that traditional drinking assessment instruments are not sensitive to differences between male and female levels of alcohol intake. Vogel-Sprott (1983) indicated that a criticism of questionnaires is that they neglect body weight and gender variables thereby ignoring the actual dose of alcohol per body weight. Another problem with using questionnaires or other self-report instruments with women alcoholics is that of women often inaccurately reporting their drinking patterns since heavy drinking has always been seen in our society as a "masculine behavior" (Hennecke & Gitlow, 1985). Thus, alcohol related problems are probably understated when women self-report alcohol use (Halliday et al, 1986).

Lindbeck (1972) stated that alcohol is used as a

solution to problems long before it becomes a cause of problems. Alan and Cooke (1984) noted that much research on alcoholics has been done by asking patients to recall events that they considered to have precipitated their drinking. Four problems with this method are identified as: (1) many of the events are as likely to be the consequences as the cause of heavy drinking, (2) the onset of excessive drinking may produce events, (3) alcoholics, are likely to generate both excessive drinking and life events, and (4) the association may reflect reporting biases; women are more likely to attribute their heavy drinking to causes which may elicit sympathy rather than censure.

Sex bias associated with staff reports of treatment outcome with individual clients may also contribute to problems in assessing the treatment effectiveness of alcoholic women. In a study conducted by Rice and Shaw (1984) where staff members were asked to evaluate a subject's appropriateness for treatment, women clients were judged less favorably for treatment. Acker's (1986) neuropsychological study went further to state that women were usually judged by staff to require a significantly longer period of abstinence before they were considered improved.

Amaro & Beckman (1984) asserted that studies of factors influencing continuation in treatment also have methodological problems. Most studies of dropout and/or treatment duration included only male subjects, did not specify sex of subjects,

or did not consider the differences between men and women.

### Influence of Specific Program Elements

Marsh and Miller (1985) explain that "sex differences in response to different modalities may be a function of the availability of specific program elements within modalities rather than modality per se." The elements of a program (i.e., specific women's services, child care) may be more important than the mode of counseling (client centered, etc.) in reaching the female client.

According to Duckert (1983), and different to the Marsh and Miller (1985) theory, women may respond better than men to intensive treatment rather than advice and certain modes of treatment may be more suitable for women than men (Cartwright, 1985).

Sauber (1983) asserted that the type of clients served in an agency greatly influences that agency's practices and services; thus, programs are developed for the majority of clients, while the minority clients are often treated as exceptions. Thus, in designing services specifically for women, it may be important not only to provide services for the women, but to also provide services for the individual differences among them (i.e., race, ethnicity, class and sexual orientation) (Underhill, 1986). Workers must have a thorough knowledge of their sample and a sensitivity to issues specific to them in order to develop programs that serve the specific needs of their population (Muchowski-Conley, 1982 &

Straussner, 1985).

Marsh and Miller (1985) stated that programs that specifically aim their components at women abusers' needs are more likely to attract clients into treatment. They mention health, housing, and child care as some specific areas. The current literature supports Marsh and Miller (1985) and adds other areas of need as important to women's programs.

Blume's (1982) article lists several factors in treating alcoholic women that include: (1) child care, (2) involvement with the family, (3) identifying prescription drug abuse, (4) improving self-esteem, (5) increased awareness of society, and (6) using recovered alcoholic women as role models for women in treatment.

Through personal interviews with alcoholic clients Beckman and Amaro (1986), found that although women abusers were three times more likely to report that they needed child care, the percentage of clients in treatment who said they need child care was very small. If a woman does need child care and the agency provides it, this removes a major barrier to treatment entry. However, the need for child care may not be as prevalent as earlier authors had thought. Beckman & Kocel (1982) suggest that programs designed to provide child care and parenting programs have been more successful in attracting and keeping women in treatment.

Another important factor listed by Blume (1986), is that of prescription drug abuse. Agencies for women should suspect

that many alcoholic women are also addicted to sedatives and other drugs. Programs that treat both problems (alcoholism and drug addiction) may be more effective in treating the population of women abusers.

Nelson & Mondanaro (1982) suggest that building behaviors that are incompatible with self-destructive drug use (i.e., health promotion) are desirable in treatment centers.

Low self-esteem in women substance abusers requires special therapeutic efforts in order to diminish this problem (Ogur, 1986). Beckman (1984), recommends that structured successful experiences help to raise the self-esteem of women alcoholics.

Because many women substance abusers have been sexually abused, Underhill (1986) recommends that an all woman's approach to treatment should be employed.

In her study of female alcoholics and significant other involvement, Muchowski-Conley (1982) administered questionnaires to alcoholic women and reported that skills listed as important to alcoholic women and important to their recovery are: (1) learning how to solve problems, (2) learning how to discuss the alcohol problem with their families and friends, and, (3) learning how to express feelings and thoughts. Most importantly, treatment should focus on the entire lifestyle of the woman abuser because most likely she will have problems in more than one aspect of her life (Miller, 1984).

## Extraprogram Factors

Beckman (1984), reported that support groups, legal services, organized recreation, and health care were all services needed by alcoholics but were usually not provided for them.

Reed (1985), suggested that the core services of an agency for women abusers should include:

### Health Needs

1. Diagnosis and treatment of medical problems
2. Gynecological services
3. Psychiatric services
4. Health promotion

### Vocational Needs

1. Job readiness training
2. Vocational skill training
3. Job-seeking support and coaching

### Legal Assistance

1. Criminal issues
2. Civil issues (divorce, custody)

### Child Related

1. Child care
2. Services to children

### Family Services

1. For significant others and the family as a whole

### Skill Training to Develop Self-Esteem and Coping

1. Assertiveness training
2. Parenting training
3. Financial management
4. Personal goal setting
5. Stress and crisis management
6. Communication skills and developing a support system
7. Discussion of gender and socialization issues
8. Basic survival skills

Education about Chemical Dependency

Basic and More Specialized Counseling

Other studies have also named one or two aspects of the above list as important to the recovery of women. Family therapy and environmental intervention (Beckman & Amaro 1986); alcohol education to employers and career planning (Amaro & Beckman, 1984); including significant others to teach them about alcoholism and improve communication skills (Muchowski-Conley, 1982); and programs that provide child care and parenting (Beckman & Kocel, 1982) have been attributed to to attracting and keeping women in treatment.

The Austin Family House (Brow & Cripps, 1985) is a treatment program for chemically dependent women and their children. It is an example of a program that includes most of the above mentioned services. It provides a combination of individual, group, and family therapy with education, counseling, social service counseling, and vocational rehabilitation counseling. Classes on alcoholism, asser-



tiveness training, polydrug abuse, alcoholic family systems, values clarification, sexuality, parenting, budgeting, fetal alcohol syndrome, relapse prevention and other relevant issues to the women abuser are presented. Individual and educational therapy are offered to children along with family therapy for women with school aged children. Overall, the program tries to integrate psychotherapy, education, case work, and Alcoholics Anonymous with love of the recovering woman's family (Brow & Cripps, 1985). Brow and Cripps (1985) reported that 75 percent of the women leaving the Austin Family House are "well" enough to continue independently.

In summary, it seems that three issues emerge in dealing with alcoholic women. First, getting women into treatment is an important task. Second, having them remain in treatment becomes important, and third, choosing the treatment that will best suit the woman and prepare her for abstinent living is important (Beckman, 1984).

Education among the support systems of recovering women may substantially effect others acceptance of the patient's disease and lead people to realize that alcoholism can be successfully treated (Beckman & Amaro, 1986). Underhill (1986) recognized that programs should be aimed at substance abusing women and they should raise these women's self-esteem and their acceptance of themselves as women. Women in early sobriety still struggle with the issues important to them

during treatment (child care, stigmatization, lack of social support, etc.). Programs that can provide these needed services may better prepare a woman to cope in her new life. Needs of recovering women include stress reduction techniques, vocational and career services, legal counseling, child care services, and access to health care services. Other issues that may be important to these women include dealing with incest, battering, child sexual abuse and sexual assault.

### Prevention

Although Marsh & Miller (1985) did not discuss the area of prevention in their article, it will be discussed here due to its importance. Prevention has been a much neglected, if not a forgotten aspect, of alcoholism and drug addiction. Taylor and St. Pierre (1986) went so far as to say that the literature provides nothing in this area. Much of the attention has been given to the person who has already become a substance abuser with little care shown for those who are at risk.

Public Law 99-570, the Anti-Drug Abuse Act of 1986, was instituted as emergency legislation authorizing 1.7 billion dollars for increased government efforts to keep a check on drugs (Schuster, 1987).

Litman's (1986) literature review on women and alcohol recommended several prevention strategies for all people. That included increased taxation on alcohol, prevention of alcohol sales in certain areas, and increased restrictions on advertising.

Recent literature has noted that early childhood experiences have been identified as a possible contributing factor in the later transition to alcoholism (Lester, 1982). Some of these experiences include: (1) disturbed parent/child relationships, (2) dependency problems, and (3) escapism among stressed individuals. Long term behavioral programs that can identify high risk young people may reduce several of the substance abuse precursors (Bry, 1983). The most effective way to reduce female substance abuse may be through primary prevention efforts (Bry, 1983) aimed at adolescent girls because of the recent increase of alcohol consumption in this group (Litman, 1986)).

Primary prevention efforts aim to stop a problem before it starts. Recognizing risk, using the media, legislation and regulation, community action groups, and health education programs are all methods of primary prevention (U.S. Department of Health and Human Services, (USDHHS) 1985).

Secondary prevention programs try to recognize those at risk for a substance abuse problem and help them minimize or eliminate the problem (USDHHS. 1981). Alcohol programs for special risk groups, employee assistance programs, getting through denial, and assessment by health professionals are all secondary prevention measures (USDHHS, 1985).

Tertiary prevention is to actually treat the problem and try to prevent any further physical, social, and emotional problems from occurring (USDHHS, 1985).

Although women tend to rate prevention efforts more negatively than do men (O'Donnell & Clinton, 1982), many prevention efforts might work for them. Because gynecologists may be the only health professional a woman seeks for help, alcohol or substance abuse screening would be beneficial during the woman's visit (Halliday et al, 1986). New programs in emergency rooms have identified many women with substance abuse problems who had not sought treatment on their own (Anderson, 1983). Another way to help women substance abusers, as suggested by Noel & McCrady (1984), is for society to establish new drinking norms among groups of women to relieve them of the stress of not knowing what constitutes appropriate behavior.

## SUMMARY

Much has been written in the last five years about women and substance abuse. Although the sheer number of studies in this area are great, very little new information has been reported. A majority of the findings reported in this review have simply confirmed an earlier finding with only occasional new information emerging. The slow advancement in the area of women and substance abuse points to the conclusion that much more work needs to be done to find optimal care techniques for women.

### Women's Use of Drugs and Alcohol

As noted in Marsh & Miller (1985) and studies presented earlier, there are many differences between men and women and their use and abuse of substances (drugs and alcohol). Most research agrees that alcohol and drugs have a more deleterious effect on women than on men in all areas of their lives (physical, psychological, family functioning). Not only are the effects of drugs and alcohol more harmful to women, women have a tendency to have cross addictions to both of these substances. With this information in hand, program developers should try to point their services in a direction that would benefit women and their specific needs such as; child care programs, development of self-esteem,

vocational training, and financial management.

### Women's Use of Treatment Services

Again, the recent studies agree with Marsh & Miller (1985) about women substance abusers, their use of treatment services, and the barriers they face to entering treatment.

Women, more specifically lower class women, have a tendency to under use treatment agencies. Reasons for this underrepresentation of women in these agencies are linked to the barriers (perceived or real) women face when entering treatment agencies. Barriers have been listed as: lack of economic resources, children, stigma, no social support, sexism, and other responsibilities. Programs that can attend to these issues should be more likely to attract and keep women in treatment. Education in all communities may help women abusers to accept and deal with their problems.

### Effective Services for Women

Because of the diversity of women's lives today, and because they differ from men, service effectiveness for women may be dependent on the inclusion of specific program elements designed especially for the substance abusing woman.

Since very few studies have been conducted with female substance abusers; and those few that have been conducted have been plagued with criticisms of their methodological design, it is hard to identify exactly which aspects of treatment are the ones needed for a program to be successful. Important components of treatment programs that seem to be effective

for women abusers are providing child care, legal assistance, vocational needs, health needs, family services, skill training, education about their abuse, and specific counseling services. The Austin Family House, as mentioned earlier, is one such program that attempts to integrate all of these aspects into the treatment of the women they serve. It seems that by incorporating all of the above aspects the Austin House is an effective treatment program for 75 percent of its clients.

Prevention programs, although rarely researched, can also be effectively aimed at women to help the potential or actual female abuser. The media and increased restrictions on alcohol and drugs might deter the use of alcohol or at least advertise where help can be found. It should be noted though, that planning effective mass media campaigns to acknowledge that there is some type of help for the female alcoholic is a complex activity, but that it is a more than worth while one.

Communities should coordinate themselves and cooperate so that communicators, market researchers, and substance abuse programmers could work together in building suitable prevention and treatment programs for substance dependent women. The program must be made to be a way to rid the woman of her problem of alcoholism or drug abuse, give her a meaningful hand back to society, and be there to support her if she feels the need to return for some type of guidance at

a later date. By promoting this type of program the women may feel that there is some hope for them and that the stigma of being an "alcoholic" or "drug abuser" has been lifted and that there is a definite method of help, not just a placebo with which to placate her until something better comes along.

With constant assistance for the woman alcoholic and her family, some form of assurance can be brought forth to enhance the adolescent in acknowledging that drinking does prove to be a problem and by recognizing it as such, can avoid it as they grow older. Such education may help to eliminate whatever pressure is brought about by the adolescent's peers to try alcohol or drugs.

The media often exploits the use of drinking on the screen and makes it appear glamorous. The media, therefore, owes it to the public to develop more programs delving into the alcoholic problems faced by both adults and adolescents. Mass produced information by the media (television, radio, pamphlets, etc.) would seem to be a method that could help in slowing down alcoholism and drug abuse by offering early education to children and adolescents.



## CONCLUSION

Although much has been written in the past 5 years about women and substance abuse, only small advances have been made in this area. Further research is mandatory and action must be taken to incorporate the new findings (i.e., accelerated onset of disease rates for women, program elements seen as attractive to female substance abusers) with previous knowledge, and this information should be put to use as soon as possible.

Research needs to now focus on identifying important program components in alcoholism treatment for women and building and evaluating prevention programs aimed at entire populations and those "at risk" for the development of alcoholism. The latter area would be greatly aided by basic research that attempts to identify behaviors, personality traits, attitudes, and environmental influences that place young women at risk for alcoholism and substance abuse.

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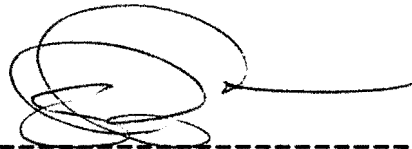
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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

4/18/88

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Date



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Director's Signature